PLAN OF CARE (POC)

Program Choice (Check all that apply):	**Plan Type:**
☐ADHC Waiver ☒EDA Waiver ☒LT-PCS	☒Initial ☐Annual ☐Status Change (Revision)

SECTION A: INDENTIFYING INFORMATION

First Name:	Middle Name:	Last Name:	Suffix:
Melvin	Joseph	Brown	Mr.

Birthdate:	Age:	Marital Status:
5/15/1926	82	☐ Never Married ☒ Married ☐Widowed ☐ Separated ☐ Divorced ☐ Other

Gender:	SSN:
☒ Male ☐ Female	000-00-1234

Race:		Medicaid No.:
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American	☐ Native Hawaiian or other Pacific Islander ☒ White/Caucasian Ethnicity: ☐ Hispanic or Latino	1234578890000 Medicare No.: Private Insurance Name: VA Benefits: ☐Yes, ☒No

Home Phone Number:	Alternate Phone Number/Cell:
225-045-5555	225-034-7777

Street Address:	City:	State:	Zip Code:
4422 Ford Road	Baton Rouge	LA	70817
Mailing Address: Same as above	City:	State: LA	Zip Code:

SECTION B: PERSONAL REPRESENTATIVE INFORMATION

First Name:	Middle Name:	Last Name:	Suffix:
Betty	Mary	Brown	Mrs.

Age:	Relationship:	Lives with Participant:	Emergency Contact :	Responsible for Evacuation:
82	Wife	☒Yes ☐No	☒Yes ☐No	☒Yes ☐No

Home Phone Number:	Alternate Phone Number/Cell: ( )
225-045-5555	

Street Address:	City:	State:	Zip Code:
4422 Ford Road	Baton Rouge	LA	70817

SECTION C: LEGAL STATUS

☐Full Interdiction ☐Limited Interdiction ☐Tutorship ☒Competent Major

SECTION D: POWER OF ATTORNEY #1

First Name:		Middle Name:	Last Name:	Suffix
Age:	Relationship:	Lives with Participant: ☐Yes ☐No	Emergency Contact : ☐Yes ☐No	Responsible for Evacuation: ☐Yes ☐No ,
Home Phone Number: ( )			Alternate Phone Number/Cell: ( )	
Street Address:		City:	State:	Zip Code:

POWER OF ATTORNEY #2

First Name:		Middle Name:	Last Name:	Suffix
Age:	Relationship:	Lives with Participant: ☐Yes ☐No	Emergency Contact : ☐Yes ☐No	Responsible for Evacuation: ☐Yes ☐No ,
Home Phone Number: ( )			Alternate Phone Number/Cell: ( )	
Street Address:		City:	State:	Zip Code:

SECTION E: HOUSEHOLD MEMBERS (Other than Participant)

NAME (First, Middle, Last & Suffix)	Age:	Relationship	This person requires Assistance to perform daily task:	This person receives HCBS (e.g., EDA, ADHC, LT-PCS, etc.) List Type(s)	Works: ☐Yes ☐No If "Yes", List Work Start/End Times	Attends School ☐Yes ☐No If "Yes", List School Start/End Times	Currently Provides Support: ☐Yes ☐No ☐Not Paid ☐ Paid Approximate hours per week:
Betty Mary Brown	82	Wife	☐Yes ☒No	☐Yes ☒No	☐Yes ☒No	☐Yes ☒No	☒Yes ☐No ☒Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid

SECTION F: FAMILY NATURAL SUPPORT/NOT LIVING IN HOUSEHOLD						
NAME (First, Middle, Last & Suffix) AND ADDRESS (Street, City, State, Zip)	Age:	Relationship	This person requires Assistance to perform daily task: ☐Yes ☐No	Works: ☐Yes ☐No If "Yes", List Work Start/End Times	Attends School ☐Yes ☐No If "Yes", List School Start/End Times	Currently Provides Support: ☐Yes ☐No ☐Not Paid ☐ Paid Approximate hours per week:
Carolyn Emily Smith – Mrs.	40	Daughter	☐Yes ☒No	☐Yes ☒No	☐Yes ☒No	☒Yes ☐No ☒Not Paid ☐ Paid
Bob Smith – Mr.	42	Son-in-Law	☐Yes ☒No	☒Yes ☐No	☐Yes ☒No	☒Yes ☐No ☒Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No ☐Not Paid ☐ Paid

SECTION G: PHYSICIAN CONTACT INFORMAITON				
Doctor's Name:	Dr. Harry Bombay	☒Primary Care	Phone Number: 225-022-0735	Date Of Last Visit/Reason: 1/2009 - Urinary Tract Infection
Doctor's Name:	Dr. Smiley	☒Specialty - Specify: Dentist	Phone Number: 225-078-9999	Date Of Last Visit/Reason: 2007 – Cavity/gum pain
Doctor's Name:	Dr. William Hunt	☒Specialty - Specify: "Diabetes Doctor"	Phone Number: 225-0777-4435	Date Of Last Visit/Reason: 12/2008 – Follow Up Visit
Doctor's Name:		☐Specialty - Specify:	Phone Number:	Date Of Last Visit/Reason:
Doctor's Name:		☐Specialty - Specify:	Phone Number:	Date Of Last Visit/Reason:

SECTION H: DISEASE DIAGNOSIS				
HEART/CIRCULATION	**NEUROLOGICAL**	**MUSCULO/SKELETAL**	**PSYCHIATRIC/MOOD**	**OTHER DISEASES**
☐Cerebrovascular Accident	☒Alzheimer's	☐Arthritis	☐psychiatric diagnosis (Specify)	☐Cancer (In past 5 years – not including skin cancer)
☐Congestive Heart Failure	☐Dementia other than Alzheimer's Disease	☐Hip Fracture	**INFECTIONS**	☒Diabetes
☐Coronary Artery Disease	☐Head Trauma	☐Other Fractures (e.g., wrist, vertebral)	☐HIV Infection	☐Emphysema/COPD/Asthma
☒Hypertension	☐Hemiplegia/Hemiparesis	☐Osteoporosis	☐Pneumonia	☐Renal Failure
☐ Irregular Pulse	☐Multiple Sclerosis	**SENSES**	☐Tuberculosis	☐Thyroid Disease (Hyper/Hypo)
☐Periph. Vascular Disease	☐Parkinsonism	☐Cataract	☐Glaucoma	☐Other Current Diagnosis (Specify)
		☐Glaucoma	☐Urinary Tract Infection (In last 30 days)	☐Other Current Diagnosis (Specify)

SECTION I: ALLERGIES
Allergies: ☒Yes (If "Yes", specify below) ☐No Known Allergies
Food Allergies (Describes what happens): Allergic to peanuts and all peanut products – Lips immediately swell up, gets "itchy mouth & throat" and starts wheezing
Medication Allergies (Describe what happens): Percocet Pain Medicine – Experiences nausea and vomiting & gets very dizzy
Environmental Allergies (Describe what happens):

SECTION J: MEDICATIONS

Include ALL Medications (e.g., Prescribed, Over the Counter Medications)

Medication	☐Recently Prescribed (RP) ☐Long Standing (LS)	Purpose	Dosage/Frequency	Route	Administered by: ☐Self (S) ☐Family (F) ☐DSW ☐Other, Specify (O,S):
Tolutamide	☐RP ☒LS	Diabetes	500 mg		☐S ☒F ☐DSW ☐O,S
HydroDiuril	☐RP ☒LS	Hypertension	25 mg		☐S ☒F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S
	☐RP ☐LS				☐S ☐F ☐DSW ☐O,S

Physician Delegation Attached if applicable ☐Yes ☒Not Applicable

Medication Management	Does Participant have any problems with medications? (check all that apply)	How does participant currently take medications? (check all that apply)
	☒Adverse reactions/allergies (see above)	☐Without assistance
	☐Forgets to take	☒With assistance from family/friends
	☐Getting to pharmacy	☐Administered by paid caregiver
	☐Cost of medication	☐Administered by health professional (nurse, doctor, etc.)
	☐Other, Specify:	☐Other, Specify:

SECTION K: MEDICAL PROCEDURES/TREATMENTS/THERAPIES					
Type	**Frequency**	**Administered by:** ☐Self (S) ☐Family (F) Medical Professional (MP) ☐Other, Specify (O,S):	**Type**	**Frequency**	**Administered by:** ☐Self (S) ☐Family (F) Medical Professional (MP) ☐Other, Specify (O,S):
☐ Oxygen		☐S ☐F ☐MP ☐O,S	☐Ventilator-Related Interventions		☐S ☐F ☐MP ☐O,S
☐Respirator or assistive breathing		☐S ☐F ☐MP ☐O,S	☐Transfusions		☐S ☐F ☐MP ☐O,S
☐Tracheal suctioning/care		☐S ☐F ☐MP ☐O,S	☐Chemotherapy		☐S ☐F ☐MP ☐O,S
☐Nebulizers		☐S ☐F ☐MP ☐O,S	☐Dialysis		☐S ☐F ☐MP ☐O,S
☐C-PAP		☐S ☐F ☐MP ☐O,S	☐Ostomy		☐S ☐F ☐MP ☐O,S
Tube Feeding ☐NG-Tube ☐Peg Tube		☐S ☐F ☐MP ☐O,S	☐Exercise Therapy		☐S ☐F ☐MP ☐O,S
☐IV Fluids/Medications		☐S ☐F ☐MP ☐O,S	☐Occupational Therapy		☐S ☐F ☐MP ☐O,S
☐Wound Care ☐Decubitus Care		☐S ☐F ☐MP ☐O,S	☐Physical Therapy		☐S ☐F ☐MP ☐O,S
☐Other, Specify		☐S ☐F ☐MP ☐O,S	☐Other, Specify		☐S ☐F ☐MP ☐O,S
Physician Delegation Attached if applicable ☐Yes ☐Not Applicable					

SECTION L: SERVICES CURRENTLY UTILIZED					
SERVICE	**PROVIDER/FREQUENCY**	**SERVICE**	**PROVIDER/FREQUENCY**	**SERVICE**	**PROVIDER/FREQUENCY**
☐ADHC Waiver		☐Home Delivered Meals		☐Councils on Aging Services	
☐EDA Waiver		☐Home Health		☐Food Bank	
☐LT-PCS		☐Hospice		☐Grant Program Services	
☐Support Coordination		☐Mental Health Services (Inpatient/outpatient)		☐Other, Specify: (e.g., Respite)	

SECTION M: ASSISTIVE DEVICES/EQUIPMENT CURRENTY UTILIZED				
Assistive Devices/ Equipment (Check all that apply)	☐Oxygen	☐ Tube Feeding	☐Slide Board	☐Dentures
	☐Respirator	☐Cane	☒ Shower Chair	☐Other, Specify:
	☐Nebulizer	☐Walker	☐Communication Device	☐Other, Specify:
	☐Suction Machine	☐Wheelchair	☐Hearing Aid	☐Other, Specify:
	☐CPAP Machine	☐ Hoyer Lift	☒Eyeglasses	☐Other, Specify:

SECTION N: EMERGENCY EVACUATION INFORMATION			
Ambulation/Locomotion: ☒No Problems ☐Limited Ability ☐Ambulatory with Aide or Device(s) ☐Non-Ambulatory			
Mode of Locomotion (Check all that apply):	☐ Walker	☐Wheelchair with Assistance	☐Scooter without Assistance
	☐ Cane	☐Wheelchair without Assistance	☐Other, Specify:
Emergency Response Level:	☐Level 1: Evacuate with Total Assistance and Life Sustaining Equipment		
	☒Level 2: Evacuate with Total Assistance		
	☐Level 3: Can Self-Evacuate but needs Transportation		
	☐Level 4: Can Self-Evacuate Independently		
Emergency Equipment In the Home:	☐Fire Extinguisher, Specify Location:		
	☐Home Evacuation Plan, Specify Location:		
	☒Smoke Detector(s), Specify Location: One in Kitchen area, and one in main hall way that leads to bedroom		
	☐Emergency Preparedness Kit, Specify Location:		
	☒First Aid Supplies, Specify Location: Kitchen cabinet next to microwave		
	☐Specialized medical Equipment (e.g., Ventilator, Suction Machine, Oxygen, etc.), Specify Location:		
	☐Other, Specify:		

Primary Person Responsible for Evacuation:	First Name: Betty	Middle Name: Mary	Last Name: Brown	Suffix: Mrs.
Lives with Participant: ☒Yes ☐No	Home Phone Number: 225-034-7777	Work/Office Number:	Cell Number:	
Works: ☐**Yes** ☒**No**	Street Address: 4422 Ford Road		Relationship:	
Attends School: ☐**Yes** ☒**No**	City: Baton Rouge	State: LA	Zip Code: 70817	
Secondary Person Responsible for Evacuation:	First Name: Carolyn	Middle Name: Emily	Last Name: Smith	Suffix: Mrs.
Lives with Participant: ☐Yes ☒No	Home Phone Number: 225-021-1124	Work/Office Number:	Cell Number: 225-063-9946	
Works: ☐**Yes** ☒**No**	Street Address: 4623 Buick Ave.		Relationship: Daughter	
Attends School: ☐**Yes** ☒**No**	City: Baton Rouge	State: LA	Zip Code: 70802	

SECTION O: PARTICIPANT PROFILE

1. Primary Concern(s)

Primary reason(s) or concern(s) that led participant/personal representative/family to seek services (Document participant's/personal representative's/family's perspective regarding what kind of assistance is being requested at this time, and why.):

Mrs. Brown and her daughter, Carolyn, report that Mr. Brown's mental functioning has declined due to his Alzheimer's disease. According to Carolyn and Mrs. Brown, Mr. Brown was diagnoses with Alzheimer's disease approximately 6 years ago and his condition has become progressively worse, especially within the past 6 months. According to Mrs. Brown and Carolyn, Mr. Brown is no longer able to take care of the majority of his personal care needs such as bathing, dressing, and grooming, and he has become incontinent of both bowel and bladder. Mrs. Brown reports that due to the increase in her husband's physical needs that require someone to help support his weight, or to steady him when he walks outside, or help with making sure he does not fall getting in and out of the bathtub, her health has been affected. Mrs. Brown reports that she is now under doctor's care for a "stomach ulcer", and that her doctor has advised her to "get someone to help out" with her husband's needs. Mrs. Mrs. Brown is requesting assistance for her husband, especially with task that require weight-bearing, or physical help. Carolyn reports that she and her husband Bob, have been assisting her mother with her father's needs, but that her husband is having to go out of town now with his job and that has put a strain on her ability to "watch the kids", and help out. Bob was also helping with Mr. Brown's bath three times week, and was shaving him during those times, but his work schedule has also impacted that area of help to the degree that he can no longer help during the week like he was doing.

2. Current Living Situation

Describe participant's current living situation (e.g., lives alone, lives with family/friends, 32 year old daughter lives with participant and currently provides some ADL and IADL assistance, participant new to this neighborhood, released from nursing facility/rehab. Facility 2 months ago, etc.)

Mr. Brown lives with his wife Betty in a single story home they have lived in since 1973. Carolyn and Bob Smith, Mr. & Mrs. Brown's daughter and son-in-law, live about 20 minutes away, and have been assisting Mrs. Brown with Mr. Brown's needs for the past 6 months. According to Mrs. .Brown, her daughter helps her with watching over her husband while she goes to the grocery store, or with staying with her husband while she goes to the doctor's office for her medical needs. Mrs. Brown reports that her husband's Alzheimer's disease has become progressively worse, causing him to "forget where he is sometimes". Mr. Brown has had some episodes of wandering out of the house recently, and Mrs. Brown and Carolyn are concerned that he will walk out into the busy street in front of the Brown's home. For that reason, Mr. Brown is never left alone. Either Mrs. Brown or Carolyn has been watching out for Mr. Brown. Mrs. Brown reports that Mr. Brown is incontinent of both bowel and bladder, and that her daughter and has been helping her recently with supporting his weight while she takes his Depends off and cleans him up. Mrs. Brown cannot support Mr. Brown's weight. Carolyn has also been helping her mother with getting her father dressed due to weight-bearing needs like getting Mr. Brown's legs in and out of pant legs, arms in his shirts, etc. Bob, Mr. Brown's son-in-law, was also assisting with bathing needs on Mon., Wed., and Friday's (e.g., getting Mr. Brown in and out of bath tub, washing and drying him off), and with shaving Mr. Brown during those days. Both Carolyn and Bob will no longer be able to assist the Brown's to the degree they were due to Mr. Smith's recent job schedule changes requiring him to be out of town more often, limiting the time he can spend helping Mr. Brown, and with caring for their children while his wife helps out her father. Mrs. Brown reports that her husband has diabetes and hypertension that have been well controlled with mediation, and that the only recent health problem, other than the Alzheimer's have been a urinary tract infection (2 months ago) that was successfully treated, and recently some problems with bleeding gums and possible dental pain related dentures not fitting properly. Mr. Brown has an appointment to see his dentist tomorrow.

SECTION O: PARTICIPANT PROFILE

1. Communication

☐ Can fully communicate with no impairment or only minor impairment (e.g., slow speech)

☐ Can fully communicate with use of assistive devices (e.g., communication board)

☒ Can communicate only basic needs to others

☐ No effective communication, depends on others to communicate needs

☐ Can understand others without difficulty
☒ Has problems understanding others (e.g., gets confused easily, does not process information well, etc.)

☒ Other, Specify: Mr. Brown has Dementia, Alzheimer's Type that causes him to mumble or ramble at times, as well as to forget familiar places, people, words, etc.

Note preferences, and other important information related to communication for this participant (e.g., speak slowly and modify tone, turn down volume on TV/radio before addressing participant, speak in direction of "good ear", make sure participant can see your lips when speaking to him/her, etc.):

Mr. Brown has a diagnoses of Dementia, Alzheimer's Type that causes him to forget familiar words and phrases. He communicates basic needs by pointing to objects, or by making motions in the direction he wants to go, for example, towards the bedroom, kitchen, Mr. Brown becomes agitated and angry when he cannot effectively communicate his needs, and sometimes screams or shouts during those times. Mrs. Brown reports that a calm, steady voice and a patient attitude help her husband stay calm and eventually, communicate his needs. Mr. Brown appeared able to understand motioning toward chair as request to sit down, firm grip on his elbow as need to get up, etc., but is limited in his ability to understand others.

2. Vision

☐ Can see adequately without assistive devices

☐ Can see adequately with use of assistive devices (e.g., eyeglasses, magnifier, etc.)

☐ Impaired - Sees large print, but not regular print

☐ Moderately Impaired – Limited vision, not able to see newspaper print but can identify objects

☒ Highly Impaired – Object identification in question, but eyes appear to follow objects

☐ Severely Impaired – No vision or sees only light, colors, or shapes, eyes do not appear to follow objects

Note preferences, and other important information related to vision for this participant (e.g., place objects to right side and in front of participant, touch lightly on hand to let participant know where objects are placed, place eyeglasses by bedside, etc.):

Carolyn and Mrs. Brown reported that although Mr. Brown wears glasses, he has been bumping into furniture lately, and that both she and her mother feel it may be related to his vision. Mr. Brown was not able to respond to questions regarding his ability to see newspaper print, book print, etc, but his eyes were able to track and follow. Mrs. Brown stated that her husband "may have cataracts". This assessor recommended a follow up appointment with eye doctor and primary care doctor to help address this issue.

SECTION O: PARTICIPANT PROFILE – Continued

3. Cognition

☐ No memory impairments evident during assessment process
☒ Short Term Memory Problem (e.g., unable to recall items after 5 minutes)
☒ Procedural Memory Problem (e.g., could not perform steps in multitask sequence without cues for initiation)
☐ No problems with Daily Decision Making
☒ Problems with Daily Decision Making
☐ Can make safe decisions in familiar/routine situations, but needs some help with decision making when faced with new tasks or situations
☒ Needs help with reminding, cueing, even with familiar routine
☒ Other, Explain: Dementia, Alzheimer's Type

Note preferences, and other important information related to cognition for this participant (e.g. use, calm even voice when cueing, provide assistance with initiation of task such as placing food on fork, make brushing motion to help initiate tooth brushing, etc.): Mr. Brown often forgets familiar people, places and how to perform everyday task, to the point that he is very dependent on his caregivers, Mrs. Brown and Carolyn, his daughter. Mr. Brown's wife and daughter report that Mr. Brown's Alzheimer's has become progressively worse in the past 6 months, and that recently he does not seem to recognize his daughter, Carolyn at times. This assessor observed Mr. Brown's apparent state of confusion when asked about what he had for lunch, Mr. Brown repeated the word "lunch", but then pointed the window and started talking about "those pretty pink and green puppies running around the yard." Mr. Brown also appeared unable to make decisions on his own, such as deciding where to sit, when to get up, and was observed attempting to pick up items from the floor that were not there. Mr. Brown's wife and daughter reported that Mr. Brown has "good days, not so good days, and bad days" related to his state of confusion, but that he seems to do better mid-morning, after he has had his breakfast and coffee. Mr. Brown is used to getting up early, and prefers to complete his bath, and other morning hygiene task in the morning, Mrs. Brown reports that Mr. Brown also seems to do better "with his memory" early in the morning, before he becomes tired out later in the day. Mrs. Brown stated that her husband also seems to responds better to a calm, strong, male voice, especially during those times when he is "having a bad day". Mrs. Brown is anxious to check with Mr. Brown's doctor to see if there is any medication that could possibly help her husband with agitation, and forgetfulness. She feels she may be able to keep her husband at home a lot longer if his "mind worked better", and stated that she wanted to do everything possible to keep him out of the nursing home.

4. Behavior

☒ Wanders (Moves without rational purpose, seemly oblivious to needs or safety)
☒ Daytime wandering but sleeps nights
☐ Wanders at night or during the day
☒ Verbally abusive behavioral symptoms (e.g., threatens or screams at others)
☐ Physically abusive behavioral symptoms (e.g., hits, shoves, scratches)
☒ Socially Inappropriate/Disruptive Behavioral symptoms (e.g., makes disruptive sounds, noises, screams)
☒ Resist care: Resisted taking medications/injections, ADL assistance, eating, or changes in position (related to cognitive issues, and not due to right to refuse care)

Note preferences, and other important information related to cognition for this participant (e.g. Use, calm even voice, gently place hand on elbow and redirect movements away from front door, back in house, make sure all door s are securely locked, etc.): Mrs. Brown reports that there has been an increase in Mr. Brown's wandering and agitation in the past two months. On two occasions in the past 3 days, Mr. Brown has wandered out into the neighborhood, and although Mrs. Brown discovered him missing after a short period of time, she is afraid that this will not always be the case. Carolyn is concerned about the wandering because her parents live on a busy street with lots of traffic, and it took the assistance of a male neighbor to get Mr. Brown back in the house when he wandered recently. Carolyn stated the neighbor, Mr. West, has agreed to "help keep an eye out" for her father, and that she has given Mr. West her and her husband's cell phone number. Mr. Brown cannot be left alone due to wandering episodes. All doors are kept securely locked. Mr. Brown has not attempted to open locked doors at this time. Place firm, but gentle hand on elbow and with calm voice redirect movements away from door.

SECTION O: PARTICIPANT PROFILE – Continued

5. Nutrition

☐ No special diet or dietary restrictions
☒ Special Diet, Specify (e.g., Diabetic Diet, No/Low Salt, No/Low Sugar, Low Fat/Cholesterol, Thickened Liquids to prevent choking):
☐ Dietary Restrictions, Specify (e.g., no nuts due to allergies):
☐ Tube feed
☐ Problems with Swallowing
☒ Problems Chewing/Chokes when eats/drinks, Specify below
☒ Problems with teeth or gums that hampers eating

Note preferences, and other important information related to nutrition for this participant (e.g., Followed by primary care physician for diabetes, prefers all liquids at room temperature, has dentures, but does not use due to painful gums, etc.): Mr. Brown is followed by his Primary Care Physician for his diabetes and requires a diabetic diet. Mrs. Brown prepares Mr. Brown's meals at this time, and expects to continue doing so. Mr. Brown can eat by himself if food is set in front of him. Mr. Brown is experiencing some difficulty with eating, possibly due to bleeding gums related to ill fitting dentures. Mr. Brown has an appointment with his dentist early next week to get this problem addressed.

6. Social Participation/Community Involvement/Leisure Activities

Are there things that the participant does that she/he finds especially enjoyable?
☐ Solitary Activities, Specify:
☐ With Groups/Clubs, Specify:
☐ Religious Activities, Specify:
☒ Visiting with friends and family
☒ Watching Television programs
☐ Other, Specify:
Are there socialization activities participant has indicated an interest in pursuing? ☐ Yes ☒ No
If "Yes", Specify:

Period of time Participant spends alone: ☒ Never or hardly ever ☐ About one hour ☐ Long periods of time ☐ All of the time

Note preferences, and other important information related to social participation, community involvement, or leisure activities for this participant (e.g. enjoys visiting with family and friends, but becomes agitated when activity takes more than one hour): Mr. Brown enjoys visiting with people from his church group and with Lions Club members from the chapter he was very involved in during previous years. Mr. Brown often does not remember names or faces, but enjoys having people visit, as long as there are not more than 3 people visiting at one time and voices are kept low and calm. Mr. Brown will turn and leave the room when he is ready for visit to be over. Mrs. Brown reports that her husband sometimes sits and watches a few minutes of a baseball game on the TV, but those times are getting far and few between lately. Mr. Brown's daughter and son-in-law, Carolyn and Bob, visit often with their children, and Mr. Brown seems to enjoy their visits as well.

SECTION O: PARTICIPANT PROFILE – Continued

7. RELATIONSHIPS

How often does Participant talk with children, family or friends, either during a visit or over the phone:

Children: ☐No Children ☒Daily ☐Weekly ☐Monthly ☐Less than Monthly ☐Never **Other Family**: ☐No Other Family ☐Daily ☐Weekly ☐Monthly ☒Less than Monthly ☐Never

Friends/Neighbors: ☐No Friends/Neighbors ☐Daily ☐Weekly ☐Monthly ☐Less than Monthly ☒Never

Note preferences, and other important information related to relationships for this participant (e.g. No immediate family or friends, would like to visit local church to develop friendships, participant has 4 children, 2 sons and 1 daughter, but only 1 of her sons lives close by and checks in on her daily, very close to his/her pets): Mrs. Brown reports that Mr. Brown has 2 older children from a previous marriage that visit him once per year. The two older children are not involved with Mr. Brown's care, but she or Carolyn have called them from time to time to let them know how Mr. Brown is doing. Mrs. Brown and Carolyn also noted that there is a neighbor, Mr. West, who recently assisted Mrs. Brown with getting Mr. Brown back home when he wandered away from home. Mr. West indicated to Carolyn and Mrs. Brown, that he would "keep an eye out" for Mr. Brown and took Carolyn and Bob's cell phone numbers, as well as Mrs. Brown's home phone number, so he could notify them in the event he sees Mr. Brown wandering again.

8. Vocational

☒Retired
☐Not Employed
☐Employed full time
☐Employed part-time

☒Not interested in pursuing a job/new job
☐Interested in pursuing a job/new job

Note preferences, and other important information related to vocational issues for this participant (e.g. Currently working at McDonalds, but would like to work at Wal-Mart):
Mr. Brown has been retired since the age of 65 from his work as an automotive parts and tire salesman, a job that he held from the time he graduated from high school.

9. Educational

Educational Level Completed: 12th grade
Can currently read: ☐Yes ☒No
Can currently write: ☐Yes ☒No
Currently enrolled in Educational Program: ☐Yes ☒No

☒Not interested in pursuing educational program/new educational program
☐Interested in pursuing educational program/new program

Note preferences, and other important information related to educational issues for this participant (e.g. Would like to take a class to learn how to read.)
Mr. Brown's ability to read and write has been affected by his progressive Alzheimer's disease. Mrs. Brown reports that she takes care of all the bill paying, with the assistance of her daughter Carolyn, and son-in-law Bob. Mr. Brown "used to enjoying reading about baseball", but has not been able to read for some time now due to Alzheimer's disease.

SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES

ACTIVITIES OF DAILY LIVING (ADLs)

Codes: MDS-HC Section H2: 0.Independent 1. Setup Help 2. Supervision (oversight, encouragement or verbal cueing)	Codes: MDS-HC (continued): 3. Limited Assistance (physical help in guided maneuvering – non-weight-bearing asst.) 4. Extensive Assistance (weight-bearing asst., active participant involvement – 50% or more of time) 5. Maximal Assistance (weight-bearing, 50% or less participant involvement) 6. Total Dependence (full performance of activity by another – participant not involved at all) 8. Activity Did Not Occur (regardless of ability)	Needs Asst. ☐No ☐Yes	Current Support How does this ADL happen for participant now? Does participant do on his/her own? Assistance devices used? Other person(s) assist? If so, who currently assist?	Type of Support Required & Preferences What is required, when, how often to assist/assure this ADL happens for participant? Who will provide support? What are participant's preferences?

ADL Task	Needs Asst.	Current Support	Type of Support Required and Preferences	Frequency and Duration of Paid Supports (Days & Approximate length of time required)
Eating MDS-HC Code: 1	Needs Asst. ☐No ☒Yes	Mr. Brown is able to feed himself with setup assistance from Mrs. Brown.	Mr. Brown is able to feed himself if food is cut up for him and placed in front of him. Mr. Brown is on a diabetic diet that he follows. Mr. Brown prefers his foods at room temperature due to sensitive gums. Mrs. Brown will continue providing eating ADL support.	None
Bathing MDS-HC Code: 5	Needs Asst. ☐No ☒Yes	Mr. Brown is not able to complete bathing ADL on his own due to his inability to get in and out of the bath tub, as well as with issues related to his ability to remember how to turn on and regulate water temperature, how to use soap and washcloth to complete bath, and how to dry off once out of tub. Mr. Brown's son-in-law, Bob has been assisting him with bathing ADL 3 times a week but is unable to continue due to conflict with new work schedule.	Mr. Brown requires regulation of water temperature, setting out of bathing articles, assistance with washing of all body parts, weight-bearing assistance getting in and out of bath tub, as well as with drying off once out of tub. Mr. Brown prefers sitting on shower chair placed inside bath tub, and use of a flexible shower hose extension with water temp set at warm level, and medium to low water flow. Mr. Brown does not respond well to rushed, jerky movements, and prefers to use washcloth to wash his own face and hands. Prefers bating in a.m. between 9 & 10 a.m.	Assistance required 5 times a week, M – F, for approximately 1 hour each morning. Bob Smith and Carolyn Smith will assist Mr. Brown with his bath during the weekends.
Dressing MDS-HC Code:	Needs Asst. ☐No ☒Yes	Mr. Brown requires weight-bearing assistance for both top and bottom dressing, specifically with lifting and placement of arms and legs in clothing, doing buttons and zippers and adjusting clothes. Mrs. Brown has been providing this ADL, but will not be able to continue with weight-bearing part of task due to her health issues.	Mr. Brown requires weight-bearing assistance with dressing both lower and upper body, buttoning of shirts, and zipping pants. Mr. Brown does not respond well to rushed, jerky movements, and prefers that caregiver tell him what part of dressing task is being performed first, second, etc.	Assistance required 5 times a week, M-F approximately 30 minutes each day, morning and late afternoon.

SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued				
ADL Task	**Needs Asst.**	**Current Support**	**Type of Support Required and Preferences**	**Frequency and Duration of Paid Supports (Days & Approximate length of time required)**
Grooming **MDS-HC Code: 5**	**Needs Asst.** ☐No ☒Yes	Mrs. Brown currently assist Mr. Brown with grooming task such as washing of hands and face, care of dentures, rinsing out of mouth, and combing of hair. Mr. Brown's son-in-law was assisting Mr. Brown with shaving task 3 times a week, but he will be unable to continue due to work schedule.	Mr. Brown requires assistance with shaving 3 times a week on Mon., Wed., and Friday. Mr. Brown responds well to calm, patient approach, and prefers task is explained to him during each level of task to avoid sudden movements.	Assistance with shaving 3 times per week on Mon., Wed., and Fri. for approximately 30 min. each day.
Transferring **MDS-HC Code: 4**	**Needs Asst.** ☐No ☒Yes	Mr. Brown currently requires weight-bearing assistance with transferring from the bed to a chair, and from sitting to standing position due to being unsteady on his feet at times. Mrs. Brown and Carolyn have been providing this assistance.	Mr. Brown requires weight-bearing transferring assistance 5 times per week, M-F. Carolyn and Bob will assist with this task on weekends. Mr. Brown responds well to calm, patient approach, and prefers task is explained to him during each level of task to avoid sudden movements.	Weight-bearing Assistance with transferring M-F for approximately 15 min. each day.
Ambulation **MDS-HC Code: 3 (outside of home)**	**Needs Asst.** ☐No ☒Yes	Mr. Brown requires limited assistance with walking outside of the home. Mrs. Brown was providing that assistance, but she is unable to continue due to her health issues.	Mr. Brown requires guided maneuvering (non-weight-bearing) with walking outside of the home 5 times per week. Mr. Brown walks without the aid of an assistive device at this time. Mr. Brown prefers short walks in his neighborhood.	Non-weight bearing assistance (guided maneuvering) required 5 times per week, M-F for approximately 30 min. each day.
Toileting **MDS-HC Code: 5**	**Needs Asst.** ☐No ☒Yes	Mr. Brown is incontinent of bowel and bladder. Mrs. Brown and Carolyn, Mr. Brown's daughter have been providing weight-bearing assistance (supporting his weight while changing Depends, washing & drying area), and assistance with clean Depends, and adjusting clothing once done.	Mr. Brown requires weight-bearing assistance with changing of Depends, washing and drying of area, and assistance with putting on clean Depends, and adjusting clothing. Mrs. Brown is not able to continue with weight-bearing assistance part of this task. Carolyn will no longer be able to provide assistance during week, but can assist on weekends. Mr. Brown needs assistance 5 times per week, M-F. Mr. Brown responds well to a male assisting with this task. Family prefers Male PCA worker.	Weight-bearing assistance 5 times per week, M-F for approximately 1 hour each day.

SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (ADLs)

Codes: MDS-HC (Section H. 1 A):	Codes: MDS-HC (Section H. 1 B):	Needs Asst.	Current Support	Type of Support Required and Preferences
0.Independent 1. Some Help 2. Full Help 3. By Others 8. Activity Did Not Occur	0. No Difficulty 1. Some Difficulty 2. Great Difficulty	☐No ☐Yes	How does this ADL happen for participant now? Does participant do on his/her own? Assistance devices used? Other person(s) assist? If so, who currently assist?	What is required, when, how often to assist/assure this ADL happens for participant? Who will provide support? What are participant's preferences?

IADL Task	Needs Asst.	Current Support	Type of Support Required and Preferences	Frequency and Duration of Paid Supports (Days & Approximate length of time required)
Light Housekeeping MDS-HC Codes: A =3 B=2	Needs Asst. ☐No ☒Yes	Mr. Brown is unable to perform this task due to cognitive issues. Mrs. Brown provides this IADL need for Mr. Brown.	Mrs. Brown will continue to provide this IADL task for Mr. Brown.	None
Food Preparation & Storage MDS-HC Codes: A =3 B=2	Needs Asst. ☐No ☒Yes	Mr. Brown is unable to perform this task due to cognitive issues. Mrs. Brown provides this IADL need for Mr. Brown.	Mrs. Brown will continue to provide this IADL task for Mr. Brown.	None
Grocery Shopping MDS-HC Codes: A =3 B=2	Needs Asst. ☐No ☒Yes	Mr. Brown is unable to perform this task due to cognitive issues. Mrs. Brown provides this IADL need for Mr. Brown.	Mrs. Brown will continue to provide this IADL task for Mr. Brown.	None

SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued				
IADL Task	**Needs Asst.**	**Current Support**	**Type of Support Required and Preferences**	**Frequency and Duration of Paid Supports (Days & Approximate length of time required))**
Laundry **MDS-HC Codes:** **A =3** **B=2**	**Needs Asst.** ☐No ☒Yes	**Mrs. Brown provides laundry needs for Mr. Brown at this time. Mr. Brown is unable to perform this task due to cognitive issues.**	**Mrs. Brown will continue providing this IADL support for Mr. Brown.**	**None**
Medication Reminders **MDS-HC Codes:** **A =3** **B=2**	**Needs Asst.** ☐No ☒Yes	**Mr. Brown is not able to manage his medications due to cognitive issues. Mrs. Brown provides all medications for her husband at this time.**	**Mrs. Brown will continue providing this IADL support for Mr. Brown.**	**None**
Assistance Scheduling Medical Appointments	**Needs Asst.** ☐No ☒Yes	**Mr. Brown is not able to manage scheduling of medical appointments due to cognitive issues. Mrs. Brown provides schedules all medical appointments for her husband at this time.**	**Mrs. Brown will continue providing this IADL support for Mr. Brown.**	**None**
Assistance Arranging Medical Transportation	**Needs Asst.** ☐No ☒Yes	**Mr. Brown is not able to manage arrangement of medical transportation for appointments due to cognitive issues. Mrs. Brown and her daughter Carolyn, provide transportation to all medical appointments for Mr. Brown.**	**Mrs. Brown will continue providing this IADL support for Mr. Brown.**	**None**
Accompanying to Medical Appointments	**Needs Asst.** ☐No ☒Yes	**Mrs. Brown and her daughter Carolyn, accompany Mr. Brown to his Medical appointments.**	**Mrs. Brown & Carolyn will continue providing this IADL support for Mr. Brown.**	**None**

SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued				
Other Tasks (Not provided by LT-PCS)				
Other Task	**Needs Asst.**	**Current Support**	**Type of Support Required and Preferences**	**Frequency and Duration of Paid Supports (Days & Approximate length of time required)**
Supervision or Assistance with Other Health Related Task	**Needs Asst.** ☐No ☒Yes	**Mrs. Brown and her daughter Carolyn assist Mr. Brown with other health related task.**	**Mrs. Brown & Carolyn will continue providing this support for Mr. Brown**	**None**
Supervision or Assistance with Community Related Task	**Needs Asst.** ☐No ☒Yes	**Currently, Mr. Brown's community connections take place in his home with regular visits from his friends. Mrs. Brown and her daughter Carolyn assist Mr. Brown with supervision during those times.**	**Mrs. Brown & Carolyn will continue providing this support for Mr. Brown**	**None**
Supervision or Assistance Related to Safety Purposes	**Needs Asst.** ☐No ☒Yes	**Mr. Brown cannot be left unattended due to safety issues related to Alzheimer's and cognitive impact on daily decision making and episodes of wandering. Mrs. Brown and Carolyn take turns "watching" Mr. Brown while other tasks are performed.**	**Mr. Brown requires supervision during times Mrs. Brown goes to the grocery store, to pick up his medications, and other related task outside of the home. Mr. Brown cannot be left unsupervised due to issues with safety related to wandering and other daily decision making impairments due to Alzheimer's disease progression. Carolyn is not longer able to assist in this area due to increased family responsibilities related to her husband's change in work schedule.**	**Supervision required 3 times per week on Mon., Wed., and Fri. for approximately 1 hour each day.**

SECTION P: ADLs, IADLs, and OTHER SUPPORTS/SERVICES - Continued

Other Services/Supports (Not provided by LT-PCS)

Other Services/ Supports	Needs Asst.	Current Support	Type of Support Required and Preferences
Personal Emergency Response System (PERS)	Needs Asst. ☒No ☐Yes	Mr. Brown has cognitive issues related to progressive Alzheimer's disease and is unable to independently respond to situations requiring emergency assistance. Mr. Brown is currently supervised at all times.	Need for emergency response is currently provided by family due to progressive cognitive issues.
Environmental Accessibility Adaptations	Needs Asst. ☒No ☐Yes	Mr. Brown is able to access his home an immediate environment at this time.	This type of support not required/requested at this time.

SECTION P ADDITONAL COMMENTS/NOTES

Mr. Brown's current ADL and IADL needs are primarily related to cognitive impairments as a result of progressive Alzheimer's disease. The family is requesting a male worker who is patient, with a calm disposition. Mr. Brown values his privacy, and is very modest, especially in the area of personal care such as toileting and bathing. Mr. Brown's family is very supportive and prefers a "hands-on" approach with the goal of keeping Mr. Brown at home for as long as possible.

SECTION Q: PARTICIPANT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE						
CAPs	**Triggered ☐ "X "if triggered**	**Planning CAP ☐Yes ☐No -** Participant declined intervention at this time	**Identified Issue/Concern**	**How is Issue/concern currently addressed/not addressed? What resources are available? What else is needed to address concern/Issue, if anything?**	**Interventions/Strategies**	**What is Anticipated Outcome?**
FUNCTIONAL PERFORMANCE						
ADL/Rehab Potential	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
IADLs	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Great difficulty level identified for all IADL related to progressive cognitive issues.**	**Primary care giver and other family members very involved with IADL support at this time. No outside intervention required at this time.**	**Primary caregiver and family will continue IADL support at this time.**	**Identified IADL supports will remain in place for next 12 months.**
Health Promotion	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Institutional Risk	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Multiple factors related to high risk for Institutionalization identified.**	**Mrs. Brown and family desire to keep Mr. Brown at home for as long as possible. They are aware of some of the challenges ahead, but indicated a desire to learn more about Alzheimer's disease.**	**ADL, IADL and emotional support will be provided to meet Mr. Brown's needs with periodic re-evaluation by Support Coordinator as needed. Referred to local Alzheimer's Association and Support Group**	**Mr. Brown will remain in his home with appropriate supports within next 12 months.**
SENSORY PERFORMANCE						
Communication Disorders	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Problem with making self understood and understanding others identified.**	**Mr. Brown is able to understand basic gestures such as pointing or motions toward chair or bed if need him to sit or go to bed. He is able to make immediate needs such as eating drinking know by pointing or making eating gestures. Mr. Brown's ability to communicate or to understands others poses a safety issue**	**Family to make works aware of how Mr. Brown communicates and how he best understands. Referred to Alzheimer's website: http://www.helpguide.org/elder/alzheimers_disease_dementias_caring_caregivers.htm & local chapter to learn about safety issues.**	**Participant will be understood and will be able to understand others within parameters of basic needs within next 12 months.**
Visual Function	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Recent problems with bumping into furniture. Family concerned that may be related to cataracts.**	**Family not sure what is causing recent visual problem. Referred to eye doctor to check on eye glass prescription and to see about possible cataracts. Referred to primary care doctor to rule out possible Alzheimer's related problems.**	**Referred to eye doctor to check on eye glass prescription, and to doctor to rule out possible Alzheimer's related problems. Make home environment as safe as possible.**	**Problems with vision will be appropriately identified and addressed within next quarter.**

SECTION Q: PARTICIPANT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE						
CAPs	**Triggered ☐ "X "if triggered**	**Planning CAP ☐Yes ☐No -** Participant declined intervention at this time	**Identified Issue/Concern**	**How is Issue/concern currently addressed/not addressed? What resources are available? What else is needed to address concern/Issue, if anything?**	**Interventions/Strategies**	**What is Anticipated Outcome?**
MENTAL HEALTH						
Alcohol Abuse & Hazardous Drinking	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Cognition	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Multiple issues ID related to cognition**	**Mr. Brown is under doctor's care for Alzheimer's disease. Expectation according to family is progressive decline. All efforts to keep Mr. Brown safe and otherwise healthy are being addressed by family.**	**Address Mr. Brown in calm, patient voice, take time with ADLs, and explain each step of task to avoid agitation and other problems.**	**Mr. Brown will remain safe and comfortable in his home within the next 12 months.**
Behavior	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Agitation and wandering behaviors.**	**Mr. Brown is never left alone due to wandering episodes related to Alzheimer's disease. Mrs. Brown plans to follow up with primary care doctor to see about recent agitation – may be related to gum pain.**	**Follow up with primary care doctor to see about possible reasons for increased agitation. Keep client safe by providing supervision at all times. Family will provide and formal support will provide.**	**Mr. Brown will remain safe, with no episodes of wandering outside of home environment within next 12 months.**
Depression & Anxiety	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Increased agitation, outbursts.**	**See Behavior CAP above**	**See Behavior CAP above**	**See Behavior CAP above**
Elder Abuse	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Social Function	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				

SECTION Q: PARTICIPANT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE						
CAPs	**Triggered ☐ "X "if triggered**	**Planning CAP** ☐**Yes** ☐**No -** Participant declined intervention at this time	**Identified Issue/Concern**	**How is Issue/concern currently addressed/not addressed? What resources are available? What else is needed to address concern/Issue, if anything?**	**Interventions/Strategies**	**What is Anticipated Outcome?**
HEALTH PROBLEMS/ SYNDROMES						
Cardio-Respiratory	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Dehydration	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Decreased food eaten in last 3 days, possibly due to ill fitting dentures causing gum pain and bleeding, increased agitation, possibly due to gum pain.**	**Appoint scheduled with dentist early next week. Need for alternate foods that are soft and will not cause gum pain. Call to dentist what can be done now, or to see if appt. can be moved up.**	**Recommended family call dentist to see if appt. can be moved up and to request interventions that may help now. May need softer foods and increase in offering room temp. liquids until problem is assessed further and resolved.**	**Participant will remain hydrated with no episodes of ER/hospital care due to dehydration during next 12 months.**
Falls	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**1 fall in last 90 days.**	**Primary caregiver is unable to support participant's weight during bathing ADL resulting in fall. No skid proof rubber mat noted in tub. Fall Risk assessment needed.**	**Fall Risk assessment to be performed at next visit. Provided Fall Risk and Prevention info. to family, recommended skid proof bath mat in tub. Bathing ADL support to be provided x 5 days, family will assist on weekends.**	**No falls related to bathing ADL will occur within next 12 months.**
Nutrition	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Decrease in food eaten in last 3 days.**	**See Dehydration CAP above**	**See Dehydration CAP above**	**See Dehydration CAP above**
Oral Health	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Problems with chewing and with use of dentures due to painful and bleeding gums.**	**See Dehydration CAP above**	**See Dehydration CAP above**	**Participant will be pain free and able to use dentures daily without incident within the next week and throughout the next 12 months thereafter.**
Pain	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**See Oral Health CAP above**	**See Oral Health CAP above**	**See Oral Health CAP above**	**See Oral Health CAP above**
Pressure Ulcers	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Fecal incontinence**	**Daily Incontinent due to cognition related issues. At risk for development of pressure ulcers – not issue at this time.**	**Alerted family to pressure ulcer risks. Toileting ADL assistance will be provided x 5 weekly with family assisting to keep Mr. Brown dry and clean after each BM.**	**Participant will remain free of pressure ulcers during the next 12 months.**
Skin & Foot Condition	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				

SECTION Q: PARTICIPANT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE - Continued						
CAPs	**Triggered** **"X" if triggered**	**Planning CAP** ☐**Yes** ☐**No -** Participant declined intervention at this time	**Identified Issue/Concern**	**How is Issue/concern currently addressed/not addressed? What else is needed to address concern/Issue, if anything?**	**Interventions/Strategies**	**What is Anticipated Outcome?**
OVERSIGHT						
Adherence	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Brittle Support System	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Medication Management	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Palliative Care	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Preventative Health	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**No test for blood in stool or screening in last 2 years.**	**Primary caregiver not aware that this was test that may be recommended for Mr. Brown, she will check with Mr. Brown's doctor at next visit.**	**Mrs. Brown will follow up with physician to see if this test is recommended for Mr. Brown.**	**Informed decision related to this screening test will be made within next 12 months.**
Psychotropic Drugs	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Reduction in Formal Services	☐	☐**Yes** ☐**No -** Participant declined intervention at this time				
Environmental Assessment	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Slippery bathroom /tub area, lives on busy traffic street**	**Supervision provided to prevent Mr. Brown from wandering in to busy street. Requesting assistance with weight-bearing for bathing task.**	**Paid support requested with weight-bearing bathing ADL Task. Recommended non-slip tub mat. Supervision to avoid wandering in to busy traffic street.**	**No falls related to environmental causes in bathroom area of home, safe from busy street within next 12 months.**

SECTION Q: PARTICIPANT ASSESSMENT PROTOCOLS (CAPSs) SUMMARY PAGE - Continued						
CAPs	**Triggered** **"X" if triggered**	**Planning CAP** ☐**Yes** ☐**No -** Participant declined intervention at this time	**Identified Issue/Concern**	**How is Issue/concern currently addressed/not addressed? What else is needed to address concern/Issue, if anything?**	**Interventions/Strategies**	**What is Anticipated Outcome?**
OVERSIGHT						
CONTINENCE						
Bowel Management	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Frequently incontinent**	**Mr. Brown's ability to distinguish when he needs to go to the restroom for a BM has been impacted by progressive cognitive issues. He wears Depends and is changed frequently with through cleaning and drying of area. He requires weight-bearing support for this ADL.**	**ADL for Toileting will be provided x 5 weekly with family providing support on weekends.**	**Bowl management will be addressed in accordance with Mr. Brown's preferences and needs within next 12 months.**
Urinary Incontinence	☒	☒**Yes** ☐**No -** Participant declined intervention at this time	**Frequently incontinent**	**See Bowel Management CAP above**	**See Bowel Management CAP above**	**See Bowel Management CAP above**

SECTION R: PLAN OF CARE (POC) Budget Page								
CPOC Start Date: 3/23/09			CPOC End Date: 3/22/2010			Total # of CPOC Days: 365		
Service Type:	**Provider Name**	**Provider #**	**Procedure Code:**	**# of Units:**	**Cost Per Unit:**	**Total Cost:**	**Start Date:**	**End Date:**
LT-PCS	Good Care, Inc.	xxxxxxx	T1019-UB	3,702	3.50	12,957.00	3/23/09	3/22/2010
EDA Waiver								
Support Coordination	XYZ, Inc.	xxxxxxx	Z0195	12	140.00	1680.00	3/23/09	3/22/2010
Transition Intensive SC								
Transition Services								
Environmental Accessibility Adaptations								
Adult Day Health Care								
Companion Services	Good Care, Inc.	xxxxxxx	S5135	626.00	2.50	1,565	3/23/09	3/22/2010
Shared CS for 2								
Shared CS for 3								
PERS Installation								
PERS								
ADHC Waiver								
Support Coordination								
ADHC								

	Total Weekly LT-PCS Costs:	$248.50	**Total Annual LT-PCS Costs:**	$12,957.00	**Total Annual Waiver Costs:**	$3,245.00
				Total Annual Cost (LT-PCS Cost + Waiver Cost) :	$16,202.00	

SECTION: S PLAN OF CARE (POC) PARTICIPANTS		
All plan of care participants must sign below indicating that he/she participated in the planning process.		
Signatures of POC Attendees:	**Relationship to Participant:**	**Date:**
	Support Coordinator/Assessor	

Signature of Reviewing Support Coordinator/Assessor Supervisor:	**Date of Review:**

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand that it is my responsibility to notify the Support Coordinator of any changes in my status which might affect the effectiveness of this program. I further agree to notify the Support Coordinator of any change in my income which might affect my financial eligibility. I understand that I have the right to accept, or to refuse all or part of the services identified in this support plan.

☐ **I accept this plan as written** ☐ **I do not accept this plan as written**

X_____ _____

☐ **Participant's Signature or** ☐ **Personal Representative's Signature** **Date:**

OAAS OR DESIGNEE PLAN OF CARE (POC) ACTION			
Date POC Accepted as Complete:			
☐ **This POC is Approved as written**	**Approval Date:**	**POC Begin Date:**	**POC End Date:**
☐ **This POC meets health and welfare needs of the person**			
☐ **This POC is Denied**	**Denial Reason:**		
☐ **This POC was referred to Service Review**	**Date:**	**Findings:**	

OAAS or Designee Authorized Representative's Signature:	**Date:**